AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Advanced IRF Boot Camp

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The Rehab Physician Gap:

Staffing, Compliance, and the Cost of Being Unprepared

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Speakers

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Disclosures

Jeffery S. Johns, M.D.
Nothing to Disclose

Darryl Kaelin, M.D.
Nothing to Disclose

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Learning Objectives

- Attendees will be able to describe PM&R training requirements that are directly applicable to the IRF level of care.
- Attendees will be able to identify some strategies to overturn denials to Acute Inpatient Rehab Facilities based on medical necessity.
- Attendees will be able to identify measurable qualities that a "Rehab Physician" as defined by the IRF should have.

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ACGME Requirements for PM&R

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- Residents must have direct and complete responsibility for the rehabilitative management of patients on the inpatient physical medicine and rehabilitation service.
  - The inpatient experience should be at least 12 months in duration.
  - Each resident assigned to an acute inpatient rehabilitation service should be responsible for a minimum of six physical medicine and rehabilitation inpatients.
  - Each resident assigned to an acute inpatient rehabilitation service should not be responsible for more than 14 physical medicine and rehabilitation inpatients.

https://www.acgme.org/globalassets/pfassets/programrequirements/2025-reformatted-requirements/340_physicalmedicinerehabilitation_2025_reformatted.pdf

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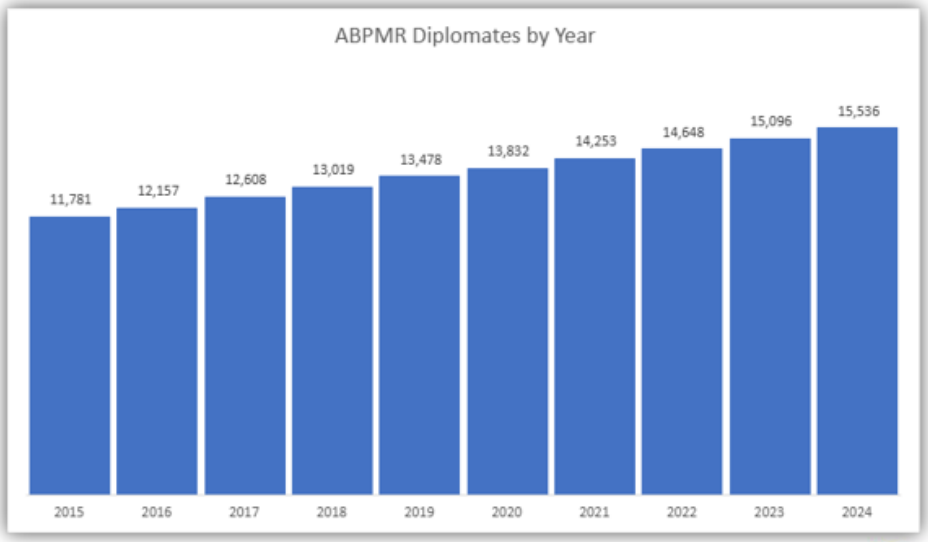
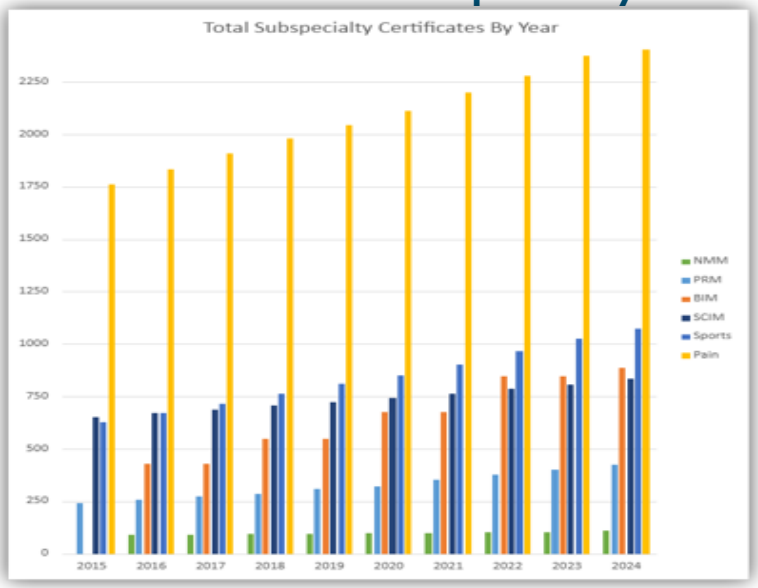
Overall Growth in ABPMR Diplomates



Source: ABPMR

Annual Growth in ABPMR Subspecialty Certification



Source: ABPMR

Market Size

Total market of board-certified practicing PM&R physicians (US based, 70 and under as retirement data is self-reported) is estimated at 13,263.

Source: AAPM&R

Primary Practice Setting

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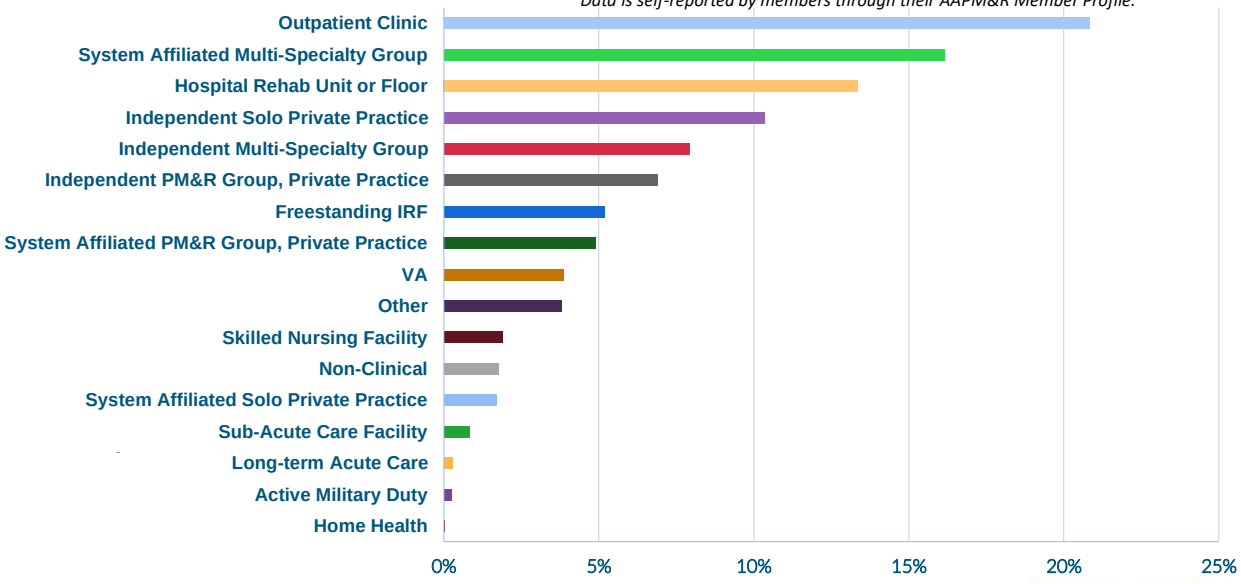
Data is self-reported by members through their AAPM&R Member Profile.



Source: AAPM&R

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Clinical Areas of Expertise

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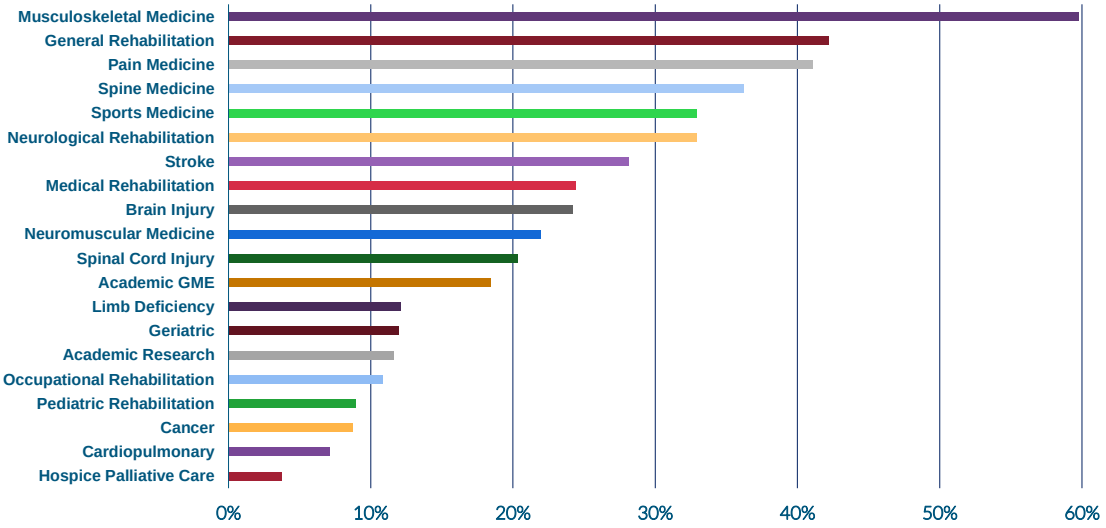
Data is self-reported by members through their AAPM&R Member Profile. Members could select more than 1 clinical area (up to 5).



Source: AAPM&R

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PM&R Workforce Gap

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- Conservative estimate = 940 physiatrists
  - Geographic imbalances will likely persist.
  - Gaps in particular practice areas and/or subspecialties may be disproportionately higher.

Dall, et al. AJPMR 2021

Considerations to Attract PM&R Physicians to IRF Practice

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- Training Factors
  - Redesign residency programs to avoid front-loading most/all inpatient experience into PGY-2 year
  - Allow inpatient training experiences to occur in community IRFs
    - Patients are likely to be less medically complex
    - Expose trainees to alternate care models that may better represent future practice options
  - Similar to "employee retention" mindset, IRFs in which residents are training should be concerned with "physician and trainee satisfaction/retention".
- Practice Factors
  - Employed physician vs non-employed physician models
    - Consider flexible options to meet physician needs/desires
  - Staff and clinical support to allow physicians to maintain outpatient or other practice components
  - Lifestyle/Burnout Considerations
    - IRF funding to support on-call coverage to minimize or eliminate that burden from PM&R physician
    - Admission timing
    - Avoid "Unfunded mandates"

Medical Necessity Denials

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- CMS IRF Regulation: In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF…
  - The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation
  - NO GOLDIE LOCKS RULE and NO CARE AT A LESSER LEVEL (2011)

- CMS IRF Guidelines

  MEDICAL NECESSITY OF IRF ADMISSION - An IRF stay will only be considered reasonable and necessary if at the time of admission to the IRF, documentation indicates a reasonable expectation of need for:
  - Complexity of the patient's nursing services
  - Close physician medical management
  - Interdisciplinary team approach for rehabilitation
  - Intensity of services needed (denial example: uncomplicated total knee replacement)
  - Therapy services intensity (denial example: majority of therapies in group setting)

Medical Necessity for Physiatric Visits

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- Physiatric visits are reasonable and medically necessary when they meet at least one of the following criteria:
- 1. Assessment of patient medical or functional complaints such as, but not limited to, pain, weakness, numbness, limited function, intellectual difficulties, reduced joint motion, or bladder or stool incontinence;
- 2. Assessment of the ability of the patient to effectively participate in rehabilitation programs;
- 3. Assessment of the appropriate site and length of treatment for various diagnoses;
- 4. Treatment of patient medical or functional complaints such as, but not limited to, pain, weakness, numbness, limited function, intellectual difficulties, reduced joint motion, or bladder or stool incontinence;
- 5. Management of medications including prescriptions related to a condition appropriate for rehabilitation;
- 6. Evaluation of impairment or disability;
- 7. Management of rehabilitation programs, including prescriptions of modalities, medical equipment including prosthetics and orthotics, or exercise programs and evaluation of patient progress;.
- 8. Communication of medical or functional problems, program needs, and progress status to patients, families, or caregivers;
- 9. Communication of diagnostic and treatment information to referring physicians; or
- 10. Revision of rehabilitation programs after significant change in the status of patients.
  - AAPM&R Position Statement

Rehabilitation Physician

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- Definition of a Rehab Physician - defined as a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation.
  - Physiatrist?
  - Neurologist with Neuro Rehab Fellowship?
  - Limited to background and training? Ortho, Neuro, Family Medicine, Rheumatology?
  - How much training? 1 year or more?
  - How much experience? 2 years or more?
  - The interdisciplinary team must be led by a rehabilitation physician and IPOC must be developed by the rehab physician after discussion and concurrence with the other team discipline's recommendations
- This has not been standardized in the industry
- How about Cardiac Care or Cancer Centers?
- Psychiatric Hospitals – CMS requires a psychiatrist

Rehab Medical Director

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- 42 C.F.R. § 412.29(G)[5] contains a definition of a director of rehabilitation which suggests that the terms "specialized training and experience" would have the meaning specified as follows "(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services."

  (1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;

  (2) Is a doctor of medicine or osteopathy;

  (3) Is licensed under State law to practice medicine or surgery; and

  (4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.
- Inpatient Psychiatric Program: The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry."

References

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- Forte GJ, Langelier M, Wang S, et al. The Physiatry Workforce in 2019 and Beyond, Part 1: Results From a Cross-sectional Survey. American Journal of Physical Medicine & Rehabilitation 100(9):p 866-876, September 2021.

- Dall TM, Reynolds RL, Chakrabarti R, et al. The Physiatry Workforce in 2019 and Beyond, Part 2: Modeling Results. American Journal of Physical Medicine & Rehabilitation 100(9):p 877-884, September 2021.